Consent to Treat a Minor -- Employee Assistance Program

Permission is granted for the Saint Alphonsus Employee Assistance Program (EAP) and its Associates and Employees to provide evaluation, counseling, and/or referral assistance to:

____________________________________ ____________________
Name of Minor Child Child's Date of Birth

I verify that I am the responsible parent or legal guardian of this child. I have had sufficient opportunity to discuss the condition, the proposed treatment, the likelihood of success, risks, benefits, and side effects of the proposed treatment, alternative treatments and non-treatment, and the likelihood of success, risks, benefits and side effects of such alternative treatments and non-treatment with my doctor, and all of my questions have been answered to my satisfaction.

I understand that I may revoke this consent at any time by informing, in writing to the EAP. Otherwise, this consent shall expire after a period of 90 days from the date of my signature below.

In consideration of this consent, I hereby release the above parties from any and all liabilities arising there from.

____________________________________ ________________
Signature of Parent of Legal Guardian Date

____________________________________ ________________
Signature of Minor (if possible) Date

____________________________________ ________________
Signature of Witness Date

Saint Alphonsus

Child Client Information Form -- Employee Assistance Program

***All identifying information is confidential, to the extent permitted by law.**

Today's Date: ________________ **Been Here Before?** ☐ Yes ☐ No **When?:** ________________

Child's Name: ________________________________ **Preferred Name:** ________________

Date of Birth: ______________ **Age:** _____ **Gender:** _____

Address: ______________________________ **City:** ______________ **State:** _____ **Zip:** __________

Cell #: ___________________________ **OK to Leave Message?:** ☐ Yes ☐ No

Email: ___________________________________ **OK to Email?:** ☐ Yes ☐ No

Mother's Name: ________________________ **Cell #:** ______________ **Home #:** _______________

Work #: _________________ **Ok to Leave Message?:** ☐ Cell ☐ Home ☐ Work

Mother's Email: ______________________________________ **OK to Email?:** ☐ Yes ☐ No

Father's Name: ________________________ **Cell #:** ______________ **Home #:** _______________

Work #: _________________ **Ok to Leave Message?:** ☐ Cell ☐ Home ☐ Work

Father's Email: ______________________________________ **OK to Email?:** ☐ Yes ☐ No

Guardian/Other: _______________________ **Cell #:** ______________ **Home #:** _______________

Work #: _________________ **Ok to Leave Message?:** ☐ Cell ☐ Home ☐ Work

Guardian/Other Email: ________________________________ **OK to Email?:** ☐ Yes ☐ No

Marital Status of Parents: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: ___________

If divorced, what are the custody arrangements?: ____

Emergency Contact: ______________________________ **Phone number:** ____________________

Referred by: ☐ Self ☐ Supervisor ☐ HR ☐ Co-worker/Friend ☐ Family

Has your child ever received any kind of counseling services? ☐ Yes ☐ No **When?:** _________

The information below pertains to the employee of the company providing this benefit.

Name of Company Providing this Benefit: ____

Employee Name: _____________________________ **Employee's Date of Birth:** ________________

Statement of Understanding -- Employee Assistance Program

Welcome to the Employee Assistance Program (EAP). Your employer sponsors this EAP to help employees and family members resolve personal problems.

SERVICES:

Your EAP counselor will help evaluate your situation and develop an action plan for resolving the problem. This action plan may include additional EAP sessions (up to the limits of your company's contract with us), or you may be referred to providers outside of the EAP who have expertise in your area of need.

The EAP ***does not provide*** long-term therapy; neither does it provide specialized evaluations such as psychological testing, custody evaluations, or court-ordered evaluations. However, we will help you identify appropriate resources to meet these needs.

CONFIDENTIALITY:

EAP services are confidential. We will not reveal information about our work with you to any outside person or agency, including your employer, without your written permission. The only exception to confidentiality is by court order, or in those situations that are life threatening, involve suspected abuse or neglect of a child or vulnerable adult, or represent the commission or threat of a crime on the EAP premises.

COSTS AND APPOINTMENTS:

EAP services are customized by the employer and usually are paid in full by the employer. Some plans may require copay after a certain number of visits. Your counselor will be able to explain the details of your plan. If you accept a referral to a provider in the community, you will be responsible for any costs associated with those services. You should check your health care benefits to determine if those costs might be covered by your health insurance.

EAP sessions will usually last 45-60 minutes. Your counselor will make every effort to begin and end the sessions on time. **If you fail to appear for a session, or cancel a session with less than 24 hour notice, we will either count that session against the total allowed by the employer or you may be charged for the time that was allotted to you, depending on your plan.** Your counselor will be able to answer questions about this policy.

THE SAINT ALPHONSUS EAP:

The Saint Alphonsus EAP is a department of Saint Alphonsus. All counselors have earned advanced degrees and maintain state licenses. If you have additional questions about the EAP, ask your EAP counselor or the Office Manager.

FEEDBACK QUESTIONNAIRE:

In order to monitor the effectiveness of the EAP and identify ways of improving our services. After we complete our work together, we would like to send you an anonymous feedback questionnaire. Please select from the following options:

☐ Please email the questionnaire to the following address: ____________________________________

☐ Please mail the questionnaire to the following address: _____________________________________

☐ No, please do not send me a feedback questionnaire.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

I have been offered the Saint Alphonsus Notice of Privacy Practices that provides information about how the facility may use and disclose Protected Health Information (PHI) for purposes of treatment, payment, and health care operations.
Please initial: _____

PATIENT RIGHTS AND RESPONSIBILITIES: I acknowledge that the Patient Rights and Responsibilities brochure was offered to me and is available in the registration area and upon request. I understand the brochure includes information about visitation rights, Advance Directives, as well as information regarding other patient rights and responsibilities.
Please initial: _____

I have read this statement and accept, understand, and acknowledge its conditions and contents.

______________________________________	______________________
Signature of Client or Legal Guardian	Date
______________________________________	______________________
Name of Client (Please Print)	Date of Birth

Rev. 11/22

Non-Discrimination Notice

Saint Alphonsus Health System, Inc. honors the sacredness and dignity of every person, complies with applicable Federal civil rights laws, and does not discriminate on the basis of protected classes, including but not limited to age, race, skin color, national origin (including ethnicity, culture, or language), religion, physical or mental disability, socioeconomic status, or sex (including sexual orientation, gender identity, or gender expression).

Saint Alphonsus Health System, Inc.:

- **Provides free aids and services to people with disabilities to communicate effectively with us, such as:**
  - Qualified sign language interpreters
  - Written information in other formats such as large print, audio, accessible electronic and other formats
- **Provides free language services to people whose primary language is not English, such as:**
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Community Services Coordinator at 1-866-727-6248.

If you believe that Saint Alphonsus Health System, Inc. has failed to provide these services or discriminated in another way on the basis of age, race, skin color, national origin (including ethnicity, culture, or language), religion, physical or mental disability, socioeconomic status, or sex (including sexual orientation, gender identity, or gender expression), you can file a grievance in person, by mail, fax or email to:

- Patient Relations Coordinator
  1055 N Curtis Road, Boise, Idaho 83706
- Phone: 208-367-6226 I Fax: 208-367-8181
- Email: BO-PatientRelations@saintalphonsus.org

If you need help filing a grievance the Patient Relations Coordinator is available to help you. You can also file a civil rights complaint with the US Department of Health & Human Services, Office for Civil Rights electronically via web, by mail or phone to:

- US Department of Health & Human Service 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201
- Web: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Phone: 1-800-368-1019 I TTY 1-800-537-7697

Saint Alphonsus

A Member of Trinity Health

Non-Discrimination Notice

Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات الترجمة اللغوية تتوافر لك بالمجان.
اتصل بالرقم: 1-866-727-6248 , (رقم هاتف الصم والبكم:1-844-801-7932)

Burmese

သတိ။ ။ သင် [ဗမာစကား] ပြောရင် ဘာသာစကားအတွက် အကူအညီပေးတဲ့ဝန်ဆောင်မှု
အခမဲ့ရနိုင်ပါတယ်။ 1-866-727-6248 TTY: 1-844-801-7932 ကို ဖုန်းဆက်ပါ။

Chinese

注意：如果您使用繁體中文, 您可以免費獲得語言援助服務
。請致電 1-866-727-6248 TTY：1-844-801-7932。

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
8426-727-668-1. با فراهم می باشد. 2397-108-448-1. تماس بگیرید.

French

ATTENTION : Si vous parlez français, des services d'aide
linguistique vous sont proposés gratuitement.
Appelez le 1-866-727-6248 ATS : 1-844-801-7932.

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-866-727-6248 TTY: 1-844-801-7932 まで、お電話にてご連絡ください。

Karen

ဟ်သူဉ်ဟ်သး မ့မ့ၢ်နတဲတၢ်ပှၤကညီကျိာ်အကိးလီတဲစိနီဉ်ဂံၢ် 8426-727-668-1
TTY: 2397-108-448-1. မၤစၢၤနၢ်သ့ဒီးစ့တလိဉ်ဘဉ်မ့အကလီ.

Kirundi

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo
gufasha mu ndimi, ku buntu. Woterefona 1-866-727-6248
TTY: 1-844-801-7932.

Korean

안내: [한국어] 를 사용하시는 경우 언어 지원 서비스를 무료 이용하실수
있습니다. 1-866-727-6248 (TTY : 1-844-801-7932) 로 전화해 주십시요.

Nepali

ध्यान दनिुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू
निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस्
1-866-727-6248 टिटिवाइ: 1-844-801-7932 ।

Pashtu

پاملرنه: که تاسو په پښتو ژبه خبرې کوئ، د ژبې وړیا مرستې خدمات
ونیسی اړیکه شمیری دی په .دي چمتو ته تاسو

Romanian

Atentie: Daca vorbesti [Romania], serviciul de asistanta lingvistic,
fara plata, este la indemana ta (disponibil). Suna la Telefonul
acesta 1-866-727-6248 sau 1-844-801-7932

Russian

ВНИМАНИЕ: Если вы говорите на русском языке,
то вам доступны бесплатные услуги перевода.
Звоните 1-866-727-6248 телетайп: 1-844-801-7932.

Serbo-Croatian

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke
pomoći dostupne su vam besplatno. Nazovite 1-866-727-6248
TTY- Telefon za osobe sa oštećenim govorom ili sluhom:
1-844-801-7932.

Somali

DIGNIIN: Haddii aad ku hadasho [luqadda ku dar], adeegyada ka
caawinta luqadda, oo lacag la'aan ah ayaa laguu heli karaa.
Wac 1-866-727-6248 (TTY: 1-844-801-7932).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios
gratuitos de asistencia lingüística. Llame al 1-866-727-6248
TTY: 1-844-801-7932.

Swahili

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata,
huduma za lugha, bila malipo. Piga simu 1-866-727-6248
TTY: 1-844-801-7932.

Urdu

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال
1-866-727-6248 کریں 1-844-801-7932

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ
miễn phí dành cho bạn.
Gọi số 1-866-727-6248 TTY: 1-844-801-7932.

Saint Alphonsus
A Member of Trinity Health

10 – 2022

Client Name: ______________________________

Date: ______________________________

Summary List -- Employee Assistance Program

	SUBSTANCE	REACTION
ALLERGIES Adverse Drug Reaction		

CURRENT MEDICATIONS/DATES		

SIGNIFICANT MEDICAL OR PSYCHIATRIC ILLNESS		

Signature: ______________________________